TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
THE CENTER FOR SPECIAL SURGERY

Respondent Name
AMERICAN ZURICH INSURANCECO

MFDR Tracking Number
M4-16-3817-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
AUGUST 24, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Carrier confirmed receipt of claim on December 18, 2016; however the claim was not reimbursed until April 5, 2016. Incidentally, I received a price negotiation form from Bridgepay (representing Broadspire) on January 11, 2016, which I declined this same day indicating TWCC allowed amount for this procedure (26615) is $5,133.98. There was not any further contact from Bridgepay."

Amount in Dispute: $4,032.54

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to the request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 17, 2015	Ambulatory Surgical Care Services CPT Code 26615-RT	$4,032.54	$591.23

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

    - 790-This charge was reimbursed in accordance to the Texas medical fee guideline.
    - P12-Workers compensation jurisdictional fee schedule adjustment.

4. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on September 1, 2016. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Issues

1. Is the requestor entitled to additional reimbursement for CPT code 26615-RT rendered on December 17, 2015?

Findings

1. The requestor is seeking additional reimbursement of $4,032.54 for ambulatory surgical care services , CPT code 26615-RT, rendered to the claimant on December 17, 2015.

    The fee guideline for Ambulatory Surgical Care services is found in 28 Texas Administrative Code §134.402.

    28 Texas Administrative Code §134.402(d) states,

    > For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section.

    CPT code 26615 is defined as "Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone."

    28 Texas Administrative Code §134.402(f)(1)(A) states,

    > The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures shall be: (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent.

    According to Addendum AA, CPT code 26615 is a non-device intensive procedure.

    The Medicare fully implemented ASC reimbursement for code 26615 CY 2015 is $735.25.

    To determine the geographically adjusted Medicare ASC reimbursement for code 26615:

    The Medicare fully implemented ASC reimbursement rate of $735.25 is divided by 2 = $367.63

    This number multiplied by the City Wage Index San Antonio is $367.63 X 0.8858 = $352.65.

Add these two together $367.63 + $352.65 = $720.28.

To determine the MAR multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235%

$720.28 X 235% = $1,692.67.

The respondent paid $1,101.44. The difference between the MAR and amount paid is $591.23; this amount is recommended for additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $591.23.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $591.23 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	10/12/2016 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.